# Committee on Resources
## Full Committee

## Testimony

**TESTIMONY OF**

**THE**

**GILA RIVER INDIAN COMMUNITY**

**BEFORE THE HOUSE COMMITTEE ON RESOURCES**

**Washington, D.C.**

**February 24, 1999**

INTRODUCTION

Good morning, Mr. Chairman and Members of the Committee. My name is Cecil Antone and I am the Lieutenant Governor of the Gila River Indian Community. I have had the privilege of serving as Lieutenant Governor since I was first elected in 1993. I am honored to have the opportunity today to represent the Gila River Indian Community before the Committee to discuss federal funding for contract support costs associated with health care programs in Indian Country ("Contract Support Costs"). This is an issue of vital importance to the health and welfare of our Community members, as well as members of the Nation's other Indian tribes.

The Gila River Indian Community (the "Community") is located on 372,000 acres in south central Arizona. Our Community is composed of approximately 19,000 tribal members, 13,000 of whom live within the boundaries of the Reservation. We have a young and rapidly growing population that presents us with a variety of health care challenges, now and in the future.

It is appropriate that the Committee has asked the Community to testify at today's hearing. Although our Community's experience with Contract Support Cost funding exposes some of the weaknesses of past funding practices, it also illustrates the significant rewards that can result when Indian tribal governments embrace the self-determination policy articulated in the Indian Self-Determination and Educational Assistance Act (□ISDEA□) by taking over operation of health care programs. We believe our story has both lessons to teach and hope to give in reaching a lasting solution to the Contract Support Cost funding issue.

We have attempted in this testimony to provide the Committee with our views with respect to the questions it has posed to the Indian Health Service (□IHS□) about Contract Support Costs. We have tried to answer those questions in the context of the story we have to tell about our experience with Contract Support Cost funding.

## THE CONTRACT SUPPORT COST ISSUE

I would like to take the opportunity to briefly present some background on the role of Contract Support Cost funding in the successful implementation of self-determination policy. Our Community believes strongly that anything less than full and recurring funding of Contract Support Costs compromises the fundamental purposes underlying the federal policy of tribal self-determination. We believe that Congress and the Administration understand this, as well. More than a decade ago, the United States Inspector General concluded that the Federal Government's payment of Indian tribal governments' Contract Support Costs enables Indian tribal governments to improve their administrative capacity and comply with federal requirements applicable to the operation of their health care programs. The Committee Report that accompanied the 1988 amendments to ISDEA went on to state as follows:

The use of indirect costs is widely accepted by state, county and local governments, and by universities, hospitals and nonprofit organizations. The most relevant issue is the need to fully fund indirect costs associated with self-determination contracts. The [Administration] should request the full amount of funds from the Congress that are adequate to fully fund tribal indirect costs. Furthermore, the Bureau of Indian Affairs and the Indian Health Service must cease the practice of requiring tribal contractors to take indirect costs from the direct program costs, which results in decreased amounts of funds for services.

Contract Support Cost funding is absolutely crucial to the ability of Indian tribal governments to operate health care programs transferred to them by IHS because those funds cover the □overhead□ and other administrative costs that Indian tribal governments incur in operating contracted federal programs. Examples of such costs include personnel, audit, financial and property management services.

In some cases, full funding for these functions cannot be transferred from the IHS to Indian tribal governments because the function is provided by a federal agency outside the IHS. For example, the Department of Justice and the Department of Health and Human Services Office of General Counsel provide IHS with legal services, the Office of Personnel Management provides IHS with personnel support and training, and the Office of Management and Budget provides IHS with budget and program policy formulation and analysis.

In other cases, IHS cannot transfer full funding for such functions because the costs are not incurred by IHS at all, but Indian tribal governments must incur the cost to operate the program. Examples of such costs include liability insurance and audit costs. When the IHS cannot directly transfer necessary resources to Indian tribal governments to support a function required by contracts with IHS, IHS is required by ISDEA to provide the Indian tribal government with Contract Support Cost funds to cover these costs.

As the Committee is aware, there is a long history of inadequate funding of Indian tribal governments' Contract Support Costs. Congress made specific amendments to ISDEA in 1988 and 1994 to remedy this problem by requiring the IHS to add to the amount available for direct program costs the full amount of Indian tribal governments' Contract Support Cost need. Nonetheless, inadequate appropriations have remained a significant obstacle to realizing the self-determination mandate. The sad result is that every un-funded dollar of Contract Support Costs must be compensated for by Indian tribal governments by reducing their level of effort to maintain administrative systems or by reallocating funds for patient services to pay administrative costs □ a result ISDEA and its amendments specifically sought to avoid. In the present environment of inadequate funding for Indian Health Services, funding for tribal health services cannot be

further diverted without having a severe impact on health care status.

The $35 million that was appropriated for Contract Support Costs in Fiscal Year 1999 was a significant accomplishment, but we must continue our work to find a reasonable, lasting solution that recognizes the validity and necessity of full and recurring Contract Support Cost funding to the realization of the goals of tribal self-determination. Any such solution must acknowledge that increases in Contract Support Cost funding are imperative and unavoidable if the true promise of the self-determination policy is to be realized.

## THE SUCCESS OF TRIBAL HEALTH CARE PROGRAMS AND SERVICES

I would like to turn now to the success of the policy of Indian self-determination. Tribal leaders have testified consistently throughout the years to the importance of the self-determination policy in building local programs and administrative infrastructure. In oversight hearings conducted in the Spring of 1987, for example, tribal leaders testified that through self-determination, Indian tribal governments experienced greater utilization of services, increased stability in tribal government and communities, and a greater focus on tribal economic development. Our Community□s experience has been the same.

Since the Community assumed local operation and management of health care services through our Department of Public Health and the Gila River Health Care Corporation (□the Corporation□), our Community has expanded and improved services in many ways. For example, we have restored services that IHS was forced to eliminate due to inadequate funding in the early 90□s and we have changed aspects of health care delivery to be more responsive to Community members.

These changes have resulted in increased outpatient visits and a redirection of services to target our Community's most serious health needs. We have made these improvements despite operating the largest component of our health care system □ the Corporation □ for three (3) years with no Contract Support Cost funding and our Department of Public Health at less than full funding. The Corporation alone has absorbed between $2 and $3 million in un-funded costs in each of the last three years.

The program funding we □lost□ as a result of having to absorb Contract Support Costs was requested and appropriated by Congress to be used to provide health care services to our Community. Moreover, it is important to remember that the IHS program funding that is made available to Indian tribal governments is 2/3 less than the average U.S. per capita expenditure for health care services for the rest of the Nation. Indian tribal governments are forced to stretch already limited health program dollars even farther when Contract Support Costs are not covered by adequate appropriations.

Our Community, fortunately, has been able to keep the level of health care service constant due to the increased control its exercises over program dollars. This control was formerly in the hands of the IHS bureaucracy. We have also increased our third party collections and received some funds from other Community sources to support increased health care services to our members. However, even after re-investing these additional resources into our program, our total funding provides approximately $1400 per patient □ well below the national average of $3046 per patient. Thus, although our Community has achieved far greater efficiencies than the IHS in utilizing scarce federal resources, the fact remains that under-funding Contract Support Costs requires our Community to use funds appropriated for services for administrative costs that are not only legitimate and reasonable, but legally required by our contracts with IHS.

Despite operating under less than ideal conditions, we believe we have made impressive strides in improving health care services, which indicates to us the promise inherent in the policy of self-

determination. For example, our Community, like many other tribal communities, is facing the challenge of a serious diabetes epidemic. The social cost of diabetes in our Community is staggering The incidence of type 2 diabetes exceeds 50% in our adult population, with an additional 10% of our members having impaired glucose tolerance. Our children are not immune from this epidemic □ over 70 children under age 18 have full-blown type 2 diabetes, which, prior to 1998, was rarely reported in the medical literature in children of this age group.

Among the many serious complications of diabetes is gangrene of the limbs, which often results in amputations. In 1988, with no podiatrist on the staff of the IHS hospital, there were twenty (20) lower extremity amputations in our Community. In the last few years, with two full-time podiatrists and a residency program in podiatry we have reduced the number of amputations to between three and five per year. While this is a significant improvement, our podiatrists need improved and immediate access to surgical facilities to further reduce and hopefully eliminate lower extremity amputations in our population.

Gum disease is another diabetes-related condition, which if left untreated can result in complete tooth loss. Our Community□s dental program now provides enhanced periodontal care for patients with diabetes. Our diabetes patients are given immediate access to appointments for examination and diagnosis and are treated utilizing a specialized protocol developed at our facility. Treating patients with this protocol has produced improvements in diabetes management as measured by glycosolates hemoglobin levels.

With over 3000 individuals in our diabetes registry, the cost of providing care continues to increase. Almost 150 of our patients are on dialysis, awaiting renal transplantation. Pharmacy costs also continue to increase at a rate that exceeds 18% per year as newer agents (such as troglitazone) are necessary to improve the management of diabetes and forestall the progression of microvascular disease and its effect on the kidney, heart, eye, and peripheral vascular systems.

In an effort to combat the severe diabetes epidemic within our population, the Community is currently pursuing a multi-disciplinary Center for Excellence for culturally appropriate approaches to the prevention of diabetes. Our Community would support special assistance by Congress to Indian tribal governments contemplating such initiatives to target the most severe health care problems plaguing Indian populations as an incentive for further health care improvements within tribal health care programs.

In addition, the limited Contract Support Cost dollars that our Department of Public Health has been receiving through its separate contracts with IHS have helped to build our health care delivery infrastructure. These Contract Support Cost funds, although funded at much less than 100% of need, have helped us create an additional executive position to further improve the management of the numerous health care programs within the Department. In addition, our Alcohol and Drug Abuse Program has been able to hire additional counselors. Other public health programs within the Community have also been able to increase services for the benefit of the Community, such as through hiring additional staff.

We are beginning to convert the Department of Public Health from an underfunded and overworked tribal health care agency into a public health agency that we believe can rival the best local and state programs. So far, we have measured the improvements in Department of Health programs in small steps, and there remains a long way to go. In October 1998, we began to examine the infrastructure that was needed by our Community to develop and maintain the necessary databases to monitor the public health status of Community members. This type of tribal-specific health information is not kept by national databases and is essential to monitoring long-term health statistics of our Community members. We are also developing an Intergovernmental Agreement between the Community and the State of Arizona dealing with areas of

mutual concern and cooperation on areas of health. In this respect, the Department of Public Health, through its self-determination efforts, has already greatly exceeded the prior efforts of IHS.

Perhaps most importantly, since taking over operation of certain health care programs, the Department of Public Health has been able to locate essential services, such as Well Child Clinics, a Wellness Center, Alcohol and Drug Abuse Program Counseling, Public Health Nurses, Community Health Representatives, and emergency medical vehicles, at accessible locations throughout our Community. These Community-based services were not even contemplated by the IHS.

These tremendous strides in health care service improvements by our Community have been made at the same time that significant cost savings have been achieved through the assumption of local operation of administrative functions. Examples include the ability to enter into contracts directly with outside service providers, typically at reduced rates based on our ability to pay invoices on time, and to hire needed personnel directly rather than going through the IHS Area Office federal personnel system, under which we had to wait an excessively long time and often accept less than ideal candidates.

## THE COMMUNITY□S EXPERIENCE WITH CONTRACT SUPPORT COST FUNDING

I would now like to discuss in more detail the Community□s experience with the under-funding of Contract Support Costs during the last three (3) years to highlight some of the problems we have encountered. In June of 1995, as the Community was preparing to contract with IHS to assume operation and management of the Community□s Hospital, our Community submitted a Contract Support Cost request of $4 million.

Because of the IHS practice of utilizing a □queue,□ or waiting list, for un-funded self-determination Contract Support Cost requests, our request was placed on the Indian Self-Determination queue (□ISD queue□) and we waited for funding. Each year we did not receive funding and but continued to track and refine our Contract Support Cost request. Eventually, our requests made it close to the □top□ of the ISD queue and we would have been funded at 100% in Fiscal Year 1999 if the ISD queue system had continued as it was operated in the past.

However, despite a backlog estimated at over $60 million in un-funded Contract Support Cost requests, the Administration requested no new funds for the ISD queue in Fiscal Year 1999. After a massive effort by Indian tribal governments and tribal supporters in Congress, $35 million in new funding was included in the Fiscal Year 1999 IHS appropriation. We understand that this will allow both our Department of Public Health and Health Care Corporation to receive approximately 70% of our Fiscal Year 1999 request.

Although we will not receive our anticipated 100% Contract Support Cost funding in Fiscal Year 1999, we support the proposed method of allocating the $35 million in new funding because we believe it goes along way toward bringing all Indian tribal governments closer to meeting their Contract Support Cost need. However, under the proposed allocation methodology, another $1.2 million of our IHS-approved Contract Support Costs will not be funded in Fiscal Year 1999. This brings our total un-funded Contract Support Costs over the last four (4) years to between 8 and 11 million dollars.

While Section 314 of the Fiscal Year 1999 IHS appropriations bill expresses the view that Indian tribal governments should not be able to collect these past due amounts, we believe this view simply invites needless litigation and would be better addressed jointly by Congress, the Administration, and Indian tribal governments discussing this issue to reach some consensus on how to address this past liability. In this regard, we need a firm commitment from Congress and the Administration that they will continue to strive

to address our past un-funded costs and to reach and maintain 100% funding for the future.

## THE NEED FOR ACCURATE CONTRACT SUPPORT COST DATA

If Congress is to commit to reaching and maintaining 100% Contract Support Cost funding, they obviously need more accurate Contract Support Cost estimates for appropriations purposes. With respect to that issue, I would now like to discuss the Committee□s concern about the lack of accurate and complete data relating to current and projected future Contract Support Costs during the last appropriations period.

As Committee Members are aware, during the Fiscal Year 1999 appropriations period, there was much discussion about how the $35 million in new funding would be allocated among the Indian tribal governments. That complex debate was made significantly more difficult due to the lack of firm Contract Support Cost numbers from IHS.

We believe the past practice of maintaining a queue and expecting that only the top $7.5 million in requests would be funded each year very likely contributed to the lack of accurate information concerning the real Contract Support Cost need for all Indian tribal governments contracting with IHS. IHS apparently did not feel compelled to scrutinize and finalize queue requests until an Indian tribal government was nearing the top of the queue. The Contract Support Cost debate during the Fiscal Year 1999 appropriations cycle required accurate numbers for all Indian tribal governments on the queue and highlighted the importance of accurate and thorough information.

IHS, and particularly the Office of Tribal Programs and Finance staff, should be commended for their efforts in the past six (6) months toward getting a handle on current Contract Support Cost needs and projecting the additional funds needed to remedy the remaining shortfalls. Now that a significant portion of the hard work has been done, it is critical that IHS Headquarters work with the Area Office staff to keep the information updated and accurate and to work more closely with Indian tribal governments to get their future Contract Support Cost needs sufficiently in advance.

## REDUCTIONS IN IHS

With respect to the Committee□s inquiries concerning the feasibility of further reductions in IHS bureaucracy, we do not believe it is necessarily possible for IHS to make parallel reductions in the IHS with each self-determination contract it enters. We would, however, like to see a dynamic change in the function, direction, and organization of the agency as more Indian tribal governments provide their own health care services. For example, in the Phoenix Area, many Indian tribal governments, unlike our Community, operate their public health programs and IHS provides the direct care.

Under the present system, these Indian tribal governments continue to need the support of an Area Office focused on the provision of direct care. At the same time, our Community no longer needs or utilizes these IHS program support functions, and where we do need such support, we generally hire appropriate personnel or contract with consultants who have the required private-sector expertise.

To support our programs, we need the IHS to work with us in a true government-to-government partnership to timely and cooperatively provide us with information pertinent to our federal funding for which it is the conduit. There should be some corresponding reduction of effort within the IHS resulting from the change in services and functions that are provided by an Indian tribal government under a self-determination contract. We support federal legislation that would provide a reduction in IHS administration, consistent with the

goals of ISDEA policies, so long as the diverse and unique needs of all Indian tribal governments are considered in any such plan.

We also acknowledge that significant barriers to downsizing IHS exist. For example, any legislation mandating reductions will have to take into account federal employment laws and how they affect the agency taking reductions commensurate with the functions that have been contracted.

As a related matter, we strongly support legislation to make self-determination permanent within the IHS, given the demonstrated success of the self-determination policy. Such legislation would be similar to H.R. 1833, co-sponsored by Chairman Young and passed by the House in the 105th Congress, which would have permanently established and implemented tribal self-governance within the Department of Health and Human Services.

## ACHIEVING THE HIGHEST LEVEL OF HEALTH CARE

Aside from reducing or reorganizing IHS, we have other suggestions as to how to achieve the highest level of tribal health care possible. For example, we believe that higher levels of health care would result from more consistent and reasonable application by IHS of the rules governing what is included in the indirect cost pool for determining indirect cost rates for Indian tribal governments. Currently, an unintended penalty is imposed on certain Indian tribal governments by the large differences in indirect cost rates negotiated by the Inspector General.

Indian tribal governments like ours with lower indirect cost rates, often due to economies of scale, receive proportionately less of the available Contract Support Cost dollars as a result. The effect is that the most efficient Indian tribal governments receive a proportionately smaller portion of available Contract Support Cost dollars. Our Community has, comparatively, a very low indirect cost rate of about 13%, compared to rates close to 100% for other Indian tribal governments. Therefore, we would support efforts by IHS to apply a more consistent and reasonable methodology to the determination of costs included in the indirect cost pool, recognizing of course the diverse needs of Indian tribal governments.

With respect to the Committee□s request for suggestions for the removal of barriers to efficient health care delivery by Indian tribal governments in order to achieve the highest level of tribal health care, our Community would support agency assistance for Indian tribal governments in accessing other federal programs that can bring in additional funds, such as those within the Centers for Disease Control and Prevention and the Office of Minority Health.

We also have some ideas in response to the Committee□s request for suggestions to increase flexibility in the administration of local health care programs. Our Community's health care programs would benefit, for example, from access to the federal Health Care Professions Fund, from which the agency currently excludes Indian tribal governments from participation. Access to the Fund would allow Indian tribal governments to identify and recruit candidates from the tribe to send to medical or business school to assume medical or executive positions within the operation of the local health care programs. The recruitment of tribal members for long-term employment within tribal health care operations is a proven way to ensure the long-term stability of tribal health care programs. In addition, currently the IHS's Prime Vendor Program requires the Corporation to purchase drugs through IHS. The Community's ability to purchase drugs on its own would result in increased cost savings and efficiency.

Although we do not have the opportunity to fully develop these and other ideas in this testimony, they may

be worth exploring further in another context in an effort to further improve the efficient delivery of tribal health care services.

## HEALTH CARE DELIVERY ALTERNATIVES

With regard to Indian tribal governments that strive for the highest health care possible but choose not to contract with IHS for local operation of health care programs, we believe it would be helpful if non-contracting Indian tribal governments had more authority to tell IHS what programs they would like to see IHS put in place to meet the specific health care needs of tribal members. Other mechanisms, such as meaningful tribal participation on IHS service unit governing boards, would assist in improving care and meeting the needs of tribal communities where a tribe does not choose to contract directly.

It is important not to lose sight of the fact, however, that new approaches to the delivery of health care cannot replace the urgent need for increases in Contract Support Cost and program funding. What Indian tribal governments need now before anything else is a firm commitment from the Administration and Congress new funds will be made available on a recurring basis to meet existing needs. Even among Indian tribal governments with dramatic records of health care improvement, there is much more to be done and much more could have been done had the Indian tribal governments received the full 100% Contract Support Cost funding to which they are entitled. The first priority, then, should be to add to the IHS budget to give Indian tribal governments 100% of their Contract Support Cost and program needs so that necessary improvements in services can be made.

## MORATORIUM

Finally, in addition to ensuring full and recurring Contract Support Cost funding for Indian tribal governments that currently have operating programs, it is vital to the policy of self-determination that Indian tribal governments have the continued right to enter into self-determination contracts in order to take over administration of health care programs and services. That is why we fully support lifting the 638 contract moratorium applied by Congress this past year on any new and expanded 638 contracts. The moratorium is a direct affront to the right of self-governance and self-determination provided to Indian tribal governments under ISDEA and is not a long-term solution to Contract Support Cost funding issues.

## CONCLUSION

These are just a few of the examples we can offer of the promise that tribal administration of health programs holds for improving the health and welfare of Indian people throughout the Nation. In order for the full promise of ISDEA to be realized, however, Congress must commit to a plan to increase funding for Contract Support Costs to an extent that will allow full and recurring funding for Contract Support Costs in future years.

The Gila River Indian Community believes strongly that the Administration, Congress, and Indian tribal governments working together can find a way to improve the mechanism for providing needed Contract Support Cost funding to Indian tribal governments. The reward will be increases in health care improvement and efficiencies in the operation of tribal health care programs throughout the Nation.

The first priority must be increasing the funding available to Indian tribal governments for Contract Support Costs to reach the goal of full and recurring Contract Support Cost funding. To that end, we seek a firm commitment from Congress that it will seek an increase in the money available to Indian tribal governments to cover Contracts Support Costs now and in the future.

We appreciate that IHS has made significant progress in addressing these issues in recent months. We encourage Congress, however, to remain committed to increasing Contract Support Costs not only within the IHS budget, but also within the Bureau of Indian Affairs budget. In addition, any proposed congressional solution to Contract Support Costs should address in a consistent manner Contract Support Costs within the IHS and the BIA, as well as any other federal agency that impacts Indian programs.

What our story and that of other Indian tribal governments demonstrates is that tribal contractors will do best when they are given the funding they need and work in a true government-to-government relationship to create solutions to their unique health care challenges. Indian tribal governments have proven that the self-governance framework can build tribal administrative capacity, reduce bureaucracy, save money, and, most importantly, improve the quality of health care services to tribal members. It is now up to all of us to find a lasting solution to Contract Support Cost funding that honors the Nation's commitment to Indian tribal governments.

# # #